SENATE BILL No. 301

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-11; IC 27-13-15.

Synopsis: Participating health providers. Establishes certain requirements concerning health care providers that enter into agreements with health insurers and health maintenance organizations with respect to claims, billing, and actions taken by a licensing authority against a provider.

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Effective: July 1, 2004.

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January 8, 2004, read first time and referred to Committee on Health and Provider Services.

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Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

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SENATE BILL No. 301

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

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4	this chapter must:
3	1, 2004]: Sec. 3.2. (a) An agreement entered into under section 3 of
2	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
1	SECTION 1. IC 27-8-11-3.2 IS ADDED TO THE INDIANA CODE

- (1) be in writing;
- (2) prohibit billing an insured for health care services for which payment by the insurer is legally required; and
- (3) provide that if the insurer fails to pay the provider for health care services for which payment by the insurer is legally required, an insured is not liable to the provider for payment for the health care services.
- (b) If an agreement entered into under section 3 of this chapter:
 - (1) is not in writing; or
 - (2) does not contain the provisions specified in subsection (a); the provider may not collect or attempt to collect from an insured payments that are liabilities of the insurer.
- SECTION 2. IC 27-8-11-7 IS ADDED TO THE INDIANA CODE



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1	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
2	1, 2004]: Sec. 7. (a) A provider that:
3	(1) does not enter into an agreement under section 3 of this
4	chapter; and
5	(2) provides emergency health care services to an insured;
6	may collect payment for the emergency health care services if the
7	provider was unaware at the time the emergency health care
8	services were rendered that the insured was covered under a policy
9	issued by an insurer that provides payment for health care services
10	under a preferred provider plan.
11	(b) A provider described in subsection (a) may collect only:
12	(1) from the insurer, the amount that would be paid for the
13	emergency health care services to a provider who has entered
14	into an agreement under section 3 of this chapter; and
15	(2) from the insured, the difference between the amount
16	charged for the emergency health care services and the
17	amount received from the insurer.
18	SECTION 3. IC 27-8-11-8 IS ADDED TO THE INDIANA CODE
19	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
20	1, 2004]: Sec. 8. (a) A provider that enters into an agreement under
21	section 3 of this chapter and submits a claim to the insurer for
22	payment for health care services provided to an insured may not
23	bill the insured for health care services for which payment by the
24	insurer is required.
25	(b) A provider that enters into an agreement under section 3 of
26	this chapter may bill, collect, and attempt to collect payment from
27	an insured only for amounts specified in the insured's policy as:
28	(1) coinsurance;
29	(2) deductibles;
30	(3) copayments; or
31	(4) payments for health care services that are not covered
32	under the policy.
33	(c) A statement sent to an insured by a provider that enters into
34	an agreement under section 3 of this chapter must:
35	(1) clearly state the amount billed to the insurer; and
36	(2) contain the following language conspicuously displayed on
37	the front of the statement in not less than 10 point boldface
38	capital letters:
39	"NOTICE: THIS IS NOT A BILL. DO NOT PAY.".
40	(d) A bill sent to an insured by a provider that enters into an
41	agreement under section 3 of this chapter must:
42	(1) clearly state any amount due that is the liability of the



1	insured; and
2	(2) contain the following language conspicuously displayed on
3	the front of the bill in not less than 10 point boldface capital
4	letters:
5	"NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY
6	AMOUNT OWED BY YOUR HEALTH INSURANCE
7	COMPANY.".
8	SECTION 4. IC 27-8-11-9 IS ADDED TO THE INDIANA CODE
9	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
10	1, 2004]: Sec. 9. (a) A provider that demands or collects payment
11	from an insured in violation of section 7 or 8 of this chapter shall
12	immediately correct the billing to the insured and refund any
13	amount paid not more than twenty-five (25) days after the provider
14	receives service of a cease and desist order by the commissioner.
15	(b) A provider that files a report with a credit reporting agency
16	for nonpayment by an insured of any amount that the provider is
17	prohibited from collecting under section 7 or 8 of this chapter is
18	liable for:
19	(1) the provision of required documentation; and
20	(2) all costs, including attorney's fees and court costs;
21	associated with correcting the erroneous credit report.
22	(c) This section is not intended to conflict with the federal Fair
23	Credit Reporting Act (15 U.S.C. 1681 et seq.).
24	SECTION 5. IC 27-8-11-10 IS ADDED TO THE INDIANA CODE
25	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
26	1, 2004]: Sec. 10. (a) As used in this section, "unbundling" means
27	the use of multiple billing codes specified in IC 27-8-22.1-5 when
28	describing individual components of a health care service rather
29	than the use of a single comprehensive billing code that describes
30	the entire health care service.
31	(b) As used in this section, "upcoding" means billing for a health
32	care service at a higher level than the level at which the health care
33	service is delivered.
34	(c) The department of insurance shall adopt rules under
35	IC 4-22-2 to prohibit a provider from:
36	(1) unbundling; and
37	(2) upcoding;
38	billing codes. The rules adopted under this subsection must be
39	consistent with transaction codes developed by the United States
40	Department of Health and Human Services under the federal
11	Health Insurance Portability and Accountability Act of 1996 (42

U.S.C. 1320D-4), as amended.



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1	(d) A provider that has entered into an agreement under section	
2	3 of this chapter and is determined by the commissioner to have	
3	engaged in unbundling or upcoding is subject to the following	
4	penalties:	
5	(1) An administrative penalty of not more than ten thousand	
6	dollars (\$10,000) for each offense.	
7	(2) A refund of all inappropriately billed charges to the	
8	insured or insurer, with interest of fifteen percent (15%) per	
9	year calculated from the date of the inappropriate billing.	
10	SECTION 6. IC 27-8-11-11 IS ADDED TO THE INDIANA CODE	
11	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY	
12	1, 2004]: Sec. 11. (a) A provider that enters into an agreement	
13	under section 3 of this chapter shall submit a claim for health care	
14	services covered under a policy issued by the insurer:	
15	(1) not more than thirty (30) business days after the date the	
16	health care services are rendered to the insured; or	
17	(2) according to the terms of the agreement.	
18	If the insurer requests additional information from the provider to	
19	justify claim payment, the provider shall submit the requested	
20	information to the insurer not more than ten (10) business days	
21	after receiving the request.	
22	(b) A provider described in subsection (a) shall request from the	
23	insurer additional time to submit a claim, if additional time is	
24	needed by the provider, not more than thirty (30) business days	
25	after the date health care services are rendered to an insured. An	
26	insurer that receives a request under this subsection shall grant an	
27	additional thirty (30) business days for the provider to submit the	
28	claim. If a provider does not submit a claim during the additional	
29	period granted under this subsection, the insurer is not required to	
30	provide payment to the provider for the claim.	
31	(c) An insurer may deduct ten percent (10%) of the total cost of	
32	a claim for every business day that a provider that enters into an	
33	agreement under section 3 of this chapter fails to submit a claim	
34	after the initial thirty (30) business day period specified in	
35	subsection (a) plus sixty (60) business days if the provider:	
36	(1) fails to submit the claim less than thirty-one (31) days after	
37	the date the health care services are rendered to an insured;	
38	and	
39	(2) has not requested an extension described in subsection (b).	
40	(d) If a provider fails to submit a claim less than thirty-one (31)	
41	days after the date health care services are rendered to an insured,	
42	IC 27-8-5.7 does not apply to the claim.	



1	(e) If an insurer:
2	(1) is not required to provide payment to a provider under
3	subsection (b); or
4	(2) is permitted to deduct an amount from the total cost of a
5	claim under subsection (c);
6	the provider shall not bill the insured for any amount that would
7	have been paid by the insurer if the provider had met the
8	requirements of this section.
9	SECTION 7. IC 27-8-11-12 IS ADDED TO THE INDIANA CODE
10	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
11	1, 2004]: Sec. 12. (a) As used in this section, "board" has the
12	meaning set forth in IC 25-1-5-2.
13	(b) If a board:
14	(1) takes action; or
15	(2) receives a report of an adverse action taken by a hospital
16	or professional review committee;
17	against a provider who is licensed, certified, registered, or
18	permitted by the board to act under IC 25, the board shall notify
19	an insurer that has provided to the board a point of contact and
20	requested that the board notify the insurer's point of contact of
21	actions against providers that have entered into an agreement
22	under section 3 of this chapter.
23	(c) An insurer may designate whether the notice required under
24	subsection (b) must be sent in written or electronic form.
25	(d) A board shall provide the notice required under subsection
26	(b) not more than ten (10) days after the end of the month in which
27	the:
28	(1) action was taken; or
29	(2) report was received;
30	by the board.
31	(e) Notice required under subsection (b) must:
32	(1) specify the action taken against the provider;
33	(2) specify the date on which the action is effective;
34	(3) specify corrective actions taken by the board, including
35	obtaining additional continuing education credits or other
36	training requirements; and
37	(4) not provide any individually identifiable health
38	information with respect to a patient of the provider.
39	(f) A limitation, restriction, suspension, or termination imposed
40	by an insurer on an agreement entered into under section 3 of this
41	chapter is effective on the date on which notice required under



subsection (b) is received by the insurer if:

(1) the insurer determines that the provider:
(A) poses an imminent threat to the health or safety of an
insured; or
(B) has:
(i) engaged in fraudulent activities with respect to the
insurer;
(ii) provided false or misleading information to the
insurer; or
(iii) withheld information from the insurer concerning
matters related to the professional conduct or
qualifications of the provider; or
(2) the action about which the insurer was notified under
subsection (b) removes or significantly impairs the ability of
the provider to render health care services to an insured.
(g) An insurer that terminates, suspends, restricts, or limits an
agreement entered into under section 3 of this chapter based on the
notice required under subsection (b) is not subject to the
requirements of section 3(c) of this chapter.
(h) A provider who is the subject of an action by an insurer to
terminate, suspend, restrict, or limit an agreement entered into
under section 3 of this chapter that is based on the notice required
under subsection (b) has no cause of action against the insurer
arising from the insurer's action.
(i) This section does not require an insurer to take any action
based on the notice received by the insurer under subsection (b).
SECTION 8. IC 27-13-15-1 IS AMENDED TO READ AS
FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 1. (a) A contract
between a health maintenance organization and a participating provider
of health care services:
(1) must be in writing;
(2) may not prohibit the participating provider from disclosing:
(A) the terms of the contract as it relates to financial or other
incentives to limit medical services by the participating
provider; or
(B) all treatment options available to an insured, including
those not covered by the insured's policy;
(3) may not provide for a financial or other penalty to a provider
for making a disclosure permitted under subdivision (2); and
(4) must provide that in the event the health maintenance
organization fails to pay for health care services as specified by
the contract, the subscriber or enrollee is not liable to the
narticinating provider for any sums owed by the health



1	maintenance organization; and
2	(5) must prohibit billing an enrollee for health care services
3	for which the health maintenance organization is liable.
4	(b) An enrollee is not entitled to coverage of a health care service
5	under a group or an individual contract unless that health care service
6	is included in the enrollee's contract.
7	(c) A provider is not entitled to payment under a contract for health
8	care services provided to an enrollee unless the provider has a contract
9	or an agreement with the carrier.
10	(d) This section applies to a contract entered, renewed, or modified
11	after June 30, 1996.
12	SECTION 9. IC 27-13-15-4 IS ADDED TO THE INDIANA CODE
13	AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
14	1, 2004]: Sec. 4. (a) A provider that:
15	(1) is not a participating provider; and
16	(2) provides emergency health care services to an enrollee;
17	may collect payment for the emergency health care services if the
18	provider was unaware at the time the emergency health care
19	services were rendered that the enrollee was covered under a
20	contract with a health maintenance organization.
21	(b) A provider described in subsection (a) may collect only:
22	(1) from the health maintenance organization, the amount
23	that would be paid for the emergency health care services to
24	a participating provider; and
25	(2) from the enrollee, the difference between the amount
26	charged for the emergency health care services and the
27	amount received from the health maintenance organization.
28	SECTION 10. IC 27-13-15-5 IS ADDED TO THE INDIANA
29	CODE AS A NEW SECTION TO READ AS FOLLOWS
30	[EFFECTIVE JULY 1, 2004]: Sec. 5. (a) A participating provider
31	that submits a claim to a health maintenance organization for
32	payment for health care services provided to an enrollee may not
33	bill the enrollee for health care services for which the health
34	maintenance organization is liable.
35	(b) A participating provider may bill, collect, and attempt to
36	collect payment from an enrollee only for amounts specified in the
37	enrollee's contract with a health maintenance organization as:
38	(1) coinsurance;
39	(2) deductibles;
40	(3) copayments; or
41	(4) payments for health care services that are not covered
42	under the contract.



1	(c) A statement sent to an enrollee by a participating provider
2	must:
3	(1) clearly state the amount billed to the health maintenance
4	organization; and
5	(2) contain the following language conspicuously displayed on
6	the front of the statement in not less than 10 point boldface
7	capital letters:
8	"NOTICE: THIS IS NOT A BILL. DO NOT PAY.".
9	(d) A bill sent to an enrollee by a participating provider must:
10	(1) clearly state any amount due that is the liability of the
11	enrollee; and
12	(2) contain the following language conspicuously displayed on
13	the front of the bill in not less than 10 point boldface capital
14	letters:
15	"NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY
16	AMOUNT OWED BY YOUR HEALTH MAINTENANCE
17	ORGANIZATION.".
18	SECTION 11. IC 27-13-15-6 IS ADDED TO THE INDIANA
19	CODE AS A NEW SECTION TO READ AS FOLLOWS
20	[EFFECTIVE JULY 1, 2004]: Sec. 6. (a) A provider that demands or
21	collects payment from an enrollee in violation of section 4 or 5 of
22	this chapter shall immediately correct the billing to the enrollee
23	and refund any amount paid not more than twenty-five (25) days
24	after the provider receives service of a cease and desist order by
25	the commissioner.
26	(b) A provider that files a report with a credit reporting agency
27	for nonpayment by an enrollee of any amount that the provider is
28	prohibited from collecting under section 4 or 5 of this chapter is
29	liable for:
30	(1) the provision of required documentation; and
31	(2) all costs, including attorney's fees and court costs;
32	associated with correcting the erroneous credit report.
33	SECTION 12. IC 27-13-15-7 IS ADDED TO THE INDIANA
34	CODE AS A NEW SECTION TO READ AS FOLLOWS
35	[EFFECTIVE JULY 1, 2004]: Sec. 7. (a) As used in this section,
36	"unbundling" means the use of multiple billing codes specified in
37	IC 27-13-41-1 when describing individual components of a health
38	care service rather than the use of a single comprehensive billing
39	code that describes the entire health care service.
40	(b) As used in this section, "upcoding" means billing for a health
41	care service at a higher level than the level at which the health care



service is delivered.

1	(c) The department of insurance shall adopt rules under
2	IC 4-22-2 to prohibit a provider from:
3	(1) unbundling; and
4	(2) upcoding;
5	billing codes. The rules adopted under this subsection must be
6	consistent with transaction codes developed by the United States
7	Department of Health and Human Services under the federal
8	Health Insurance Portability and Accountability Act of 1996 (42
9	U.S.C. 1320D-4), as amended.
10	(d) A participating provider that is determined by the
11	commissioner to have engaged in unbundling or upcoding is
12	subject to the following penalties:
13	(1) An administrative penalty of not more than ten thousand
14	dollars (\$10,000) for each offense.
15	(2) A refund of all inappropriately billed charges to the
16	enrollee or health maintenance organization, with interest of
17	fifteen percent (15%) per year calculated from the date of the
18	inappropriate billing.
19	SECTION 13. IC 27-13-15-8 IS ADDED TO THE INDIANA
20	CODE AS A NEW SECTION TO READ AS FOLLOWS
21	[EFFECTIVE JULY 1, 2004]: Sec. 8. (a) A participating provider
22	shall submit a claim for health care services covered under a
23	contract with a health maintenance organization:
24	(1) not more than thirty (30) business days after the date the
25	health care services are rendered to the enrollee; or
26	(2) according to the terms of the participating provider's
27	contract with the health maintenance organization.
28	If a health maintenance organization requests additional
29	information from a participating provider to justify claim
30	payment, the participating provider shall submit the requested
31	information to the health maintenance organization not more than
32	ten (10) business days after receiving the request.
33	(b) A participating provider described in subsection (a) shall
34	request from the health maintenance organization additional time
35	to submit a claim, if additional time is needed by the participating
36	provider, not more than thirty (30) business days after the date
37	health care services are rendered to an enrollee. A health
38	maintenance organization that receives a request under this
39	subsection shall grant an additional thirty (30) business days for
40	the participating provider to submit the claim. If a participating
41	provider does not submit a claim during the additional period
42	granted under this subsection, the health maintenance organization



1	is not required to provide payment to the participating provider
2	for the claim.
3	(c) A health maintenance organization may deduct ten percent
4	(10%) of the total cost of a claim for every business day that a
5	participating provider fails to submit a claim after the initial thirty
6	(30) business day period specified in subsection (a) plus sixty (60)
7	business days if the participating provider:
8	(1) fails to submit the claim less than thirty-one (31) days after
9	the date health care services are rendered to an enrollee; and
10	(2) has not requested an extension described in subsection (b).
11	(d) If a participating provider fails to submit a claim less than
12	thirty-one (31) days after the date health care services are
13	rendered to an enrollee IC 27-13-36.2 does not apply to the claim.
14	(e) If a health maintenance organization is:
15	(1) not required to provide payment to a participating
16	provider under subsection (b); or
17	(2) is permitted to deduct an amount from the total cost of a
18	claim under subsection (c);
19	the participating provider may not bill the enrollee for any amount
20	that would have been paid by the health maintenance organization
21	if the participating provider had met the requirements of this
22	section.
23	SECTION 14. IC 27-13-15-9 IS ADDED TO THE INDIANA
24	CODE AS A NEW SECTION TO READ AS FOLLOWS
25	[EFFECTIVE JULY 1, 2004]: Sec. 9. (a) As used in this section,
26	"board" has the meaning set forth in IC 25-1-5-2.
27	(b) If a board:
28	(1) takes action; or
29	(2) receives a report of an adverse action taken by a hospital
30	or professional review committee;
31	against a participating provider who is licensed, certified,
32	registered, or permitted by the board to act under IC 25, the board
33	shall notify a health maintenance organization that has provided
34	to the board a point of contact and requested that the board notify
35	the health maintenance organization's point of contact of such
36	actions against participating providers.
37	(c) A health maintenance organization may designate whether
38	the notice required under subsection (b) must be sent in written or
39	electronic form.
40	(d) A board shall provide the notice required under subsection
41	(b) not more than ten (10) days after the end of the month in which

the action was taken or the report was received by the board.



1	(e) Notice required under subsection (b) must:	
2	(1) specify the action taken against the participating provider;	
3	(2) specify the date on which the action is effective;	
4	(3) specify corrective actions taken by the board, including	
5	obtaining additional continuing education credits or other	
6	training requirements; and	
7	(4) not provide any individually identifiable health	
8	information with respect to a patient of the participating	
9	provider.	
10	(f) A limitation, restriction, suspension, or termination imposed	
11	by a health maintenance organization on a contract entered into	
12	with a participating provider under this chapter is effective on the	
13	date on which notice required under subsection (b) is received by	
14	the health maintenance organization if:	
15	(1) the health maintenance organization determines that the	_
16	participating provider:	
17	(A) poses an imminent threat to the health or safety of an	
18	enrollee; or	
19	(B) has:	
20	(i) engaged in fraudulent activities with respect to the	
21	health maintenance organization;	
22	(ii) provided false or misleading information to the	
23	health maintenance organization; or	
24	(iii) withheld information from the health maintenance	
25	organization concerning matters related to the	
26	professional conduct or qualifications of the	
27	participating provider; or	
28	(2) the action about which the health maintenance	V
29	organization was notified under subsection (b) removes or	
30	significantly impairs the ability of the participating provider	
31	to render health care services to an enrollee.	
32	(g) A participating provider who is the subject of an action by	
33	the health maintenance organization to terminate, suspend,	
34	restrict, or limit a contract entered into under this chapter that is	
35	based on the notice required under subsection (b) has no cause of	
36	action against the health maintenance organization arising from	
37	the health maintenance organization's action.	
38	(h) This section does not require a health maintenance	
39	organization to take any action based on the notice received by the	

health maintenance organization under subsection (b).

